Testimony prepared for the members of the

JOINT LEGISLATIVE BUDGET COMMITTEE

FY 2023 Executive Budget Proposals: Health/Medicaid

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The New York State Council for Community Behavioral Healthcare ("The NYS Council") represents the interests of 107 mental health and substance use disorder / addiction providers situated in local communities across New York. Our members provide these critical services in a variety of settings including freestanding nonprofit organizations, through County Departments of Mental Hygiene, and general hospitals.

Each year I testify before this Committee because the individuals we serve have numerous complex health needs that don't fall neatly into one area of the budget. Their physical health issues are dramatically impacted by their ongoing behavioral health conditions, and vice versa. Approximately 80% of the individuals we serve are Medicaid beneficiaries and so, state Medicaid policy is of primary concern to our members and the individuals they work with. As such, I appreciate the opportunity to appear before you today to discuss the following executive budget proposals under the purview of this Committee:

- **Support** for HMH, Article VII, Part P – Establishing a Competitive Bid Process for procurement of Managed Care Organizations participating in the Medicaid managed care carve-in of various special needs populations
- **Support** for HMH, Article VII, Part FF – Reinvests funds with OMH and OASAS that are associated with overpayments made to certain MCOs that failed to meet expenditure targets
- **Support** for HMH, Article VII, Part LL – Extends APG government rates for BH services through 2027
- **Request to Expand HMH, Article VII, Part B** - Removes requirement for NP in **primary care** with over 3600 hours experience to maintain a collaborative relationship with physicians
- **Support** for HMH, Article VII, Part V - Establishes Telehealth Payment Parity for Medicaid and commercial insurance
- **Opposition** to HMH, Article VII, Part BB – To eliminate Prescriber Prevails option in Medicaid Managed Care & Medicaid FFS
- **Support** for Improving access to children's mental & behavioral health services by aligning Child Health Plus benefits with other Medicaid benefits (HMH, Article VII, Part U)
- **Support** for Expanding Access to Naloxone and Buprenorphine in Pharmacies (HMH, Article VI, Part EE)
- **Support** for proposal to provide Healthcare Workforce bonuses to Health and Mental Hygiene employees (HMH Article VII, Executive, Part D)
- **Support** for ATL OASAS SFY 2022-2023 Executive Budget Bill – Support appropriation of $1.5M from Behavioral Health Parity Compliance Enforcement Fund

HMH, Article VII, Part P: Competitive Bid procurement to identify MCOs to participate in carve in of special needs populations to Medicaid managed care

Behavioral health services for Medicaid recipients with serious mental health and/or substance use conditions have been carved into Medicaid managed care since 2015. During this time, many MCOs participating in the carve in have proven to be unfit to manage these benefits. To date, the state has issued over 150 citations to MCOs for a variety of deficiencies, and yet in these instances, MCOs have rarely changed their practices. Instead, it appears MCOs that are repeatedly cited see these citations as trivial. However, participation in the carve-in is not an entitlement. Management of benefits for vulnerable New Yorkers should be treated seriously and New York should make every effort to identify only those vendors who are up to the job.

Of the 40 states across the country that operate Medicaid managed care programs, only 3 continue to utilize an 'application' process to identify MCOs, with New York being one of these. Most states select vendors using a competitive bid process that, if employed here in New York, would **allow stakeholders to contribute to the discussion of the competencies and attributes they want in a managed care company while simultaneously weeding out those companies that should not be managing care for some of our most vulnerable citizens**. Use of a competitive procurement process will have the effect of **forcing interested vendors to intensify their commitments and increase their quality outcomes so they can participate and remain in the carve in.** Companies with a poor track record or an obvious indifference to the task of managing benefits for vulnerable populations will be removed. New York needs this process to ensure Medicaid beneficiaries receive the best care possible from companies that are interested in more than just making a profit.

The 2015 carve in of New York's behavioral health services has resulted in serious problems for providers, and more importantly, for care recipients. OMH, OASAS and DOH have issued **over 150 citations to various insurers for their failure to comply with requirements in two main categories: federal and state parity laws, and inappropriate claims denials.** Vulnerable Medicaid recipients whose lives depend on these services should not have their benefits managed by companies who regularly violate federal and state laws. At this point, the state has more than enough information regarding the insurers participating in the BH carve in to make educated decisions as to which of these vendors has what it takes to continue to serve vulnerable new Yorkers and meet contract and regulatory requirements. **New York should utilize a competitive procurement process and then commit to a schedule that requires these companies to re-bid for inclusion on a regular basis.** This will raise the bar for those who want to partner with the state in this endeavor.

At the present time, the state uses an antiquated method for identifying insurers requiring them to **meet minimum standards to participate.** The result is a group of MCOs only some of which are truly capable of performing the tasks and activities they are paid to carry out. Providers spend countless hours meeting the requirements of these MCOs that all have different forms and policies. Providers that serve vulnerable New Yorkers should not have to employ an army of back-office staff whose primary job responsibility is to chase late payments and prepare complaints they then submit to the state, seeking intervention and protection in transactions with certain MCOs. Imagine the efficiencies we could achieve if plans were motivated to process claims correctly and on time, and back office staff could be re-tasked to focus on quality of care and other access to care issues impacting clients.

Our association vigorously supports this proposal. **We also have suggestions for additional criteria the state should consider when identifying companies that manage insurance benefits for special needs populations to ensure there are strong guardrails in place to protect consumers and providers. At the end of this**

testimony, we have listed some additional criteria the state should consider in a competitive bid process for the identification of MCOs that will participate in the carve in of behavioral health services going forward.

HMH, Article VII, Part FF – Reinvests funds with OMH and OASAS that are associated with overpayments made to certain MCOs that failed to meet expenditure targets

Fifteen months ago, our association began to pursue information pertaining to performance of MCOs in the carve-in of behavioral health services. At the time we had reason to believe the state had failed to recoup premiums paid to MCOs that had failed to meet expenditure targets including Medical Loss Ratios and Behavioral Health Expenditure Targets, as required. Through our attorneys, we issued some 20 FOILs seeking performance information as well as other information related to state enforcement of laws, regulations, and contract provisions. We were able to confirm that the state had not enforced expenditure targets. We also learned that the state had failed to promulgate a regulation that was required to describe the methodology the state would use to calculate savings associated with the carve in of our services – savings that are required to be reinvested with OMH and OASAS. Ultimately, and with the assistance of Assemblyman Gottfried and Senator Rivera, we were able to compel the Administration to collect two years of overpayments made by the state to certain MCOs that had failed to meet expenditure targets. Part FF reflects the outcome of our advocacy that was focused on recovering scarce resources that were due to be reinvested with the state agencies that are ultimately responsible for assuring adequate access to care for New Yorkers living with serious mental health and substance use disorder conditions. We urge this Committee to vigorously support this proposal and to re-double your efforts to ensure that all laws, regulations, and contractual obligations required of MCOs are enforced by the state and specifically, by the Office of Health Insurance Programs at the Department of Health.

HMH, Article VII, Part LL – Extends APG government rates for BH services through 2027

In 2010, our Association spent a full year leading an advocacy effort designed to address the reimbursement crisis facing mental health and substance use disorder providers whose rates were going to change as the result of the carve-in of behavioral health services to Medicaid managed care. Outpatient Clinic reimbursement rates were deeply insufficient and had been for over a decade. Other rates for core services that are foundational to the recovery of so many New Yorkers who receive assistance from the public mental hygiene system were also deeply insufficient. The carve-in of our services to Medicaid managed care would have resulted in rates for critical programs and services across our system of care falling off a cliff had we been left to negotiate all rates with MCOs. One has only to look at reimbursement rates paid to these providers when they serve clients with private insurance (on average 50% less than our current Medicaid rates) to know that the bottom would have fallen out without rate protections as we moved to managed care.

We were pleased when the Executive and the Legislature agreed to establish a continuous rate for these services in 2010, thereby stabilizing the programs and services that were in severe fiscal distress. Over the years we have come to this body seeking increases for these services that have not kept up inflation, putting incredible stress on our system of care. Today we come before this body to advocate for the continuation of what we commonly refer to as APG government rates through 2027. This year many of the Programs and Services that currently receive an APG government rate will be getting rate increases in large part due to federal enhanced FMAP funds made available as result of COVID Relief funds. It is our understanding at this juncture that these increases will largely be permanent and will increase the base rates for critical programs and services including the OASAS and OMH Outpatient Clinics, PROS and ACT. But these increases are only meaningful if the APG government rate is continued.

Behavioral health providers do not have the bargaining power or leverage to negotiate satisfactory rates and need the rate continuity provided by the APG government rates. We ask this Committee to support this

proposal without reservation and in doing so, continuing to protect the fragile safety net system New York has built for New Yorkers with serious mental health and/or substance use disorder challenges.

HMH, Article VII, Part V - Establishes Telehealth Payment Parity for Medicaid and commercial insurance

The availability of telehealth services for New Yorkers with mental health and/or substance use disorder challenges has been an absolute gamechanger. Access to care for those New Yorkers who, for a variety of reasons including their inability to travel to care due to work conflicts or the expense associated with travel, has opened the door to services for thousands of New Yorkers who would otherwise have been unable to receive assistance through the public mental hygiene system. For providers, the ability to meet the client where he/she is at, and to provide services on demand has meant that more individuals in their care had choices about what was best for the client, rather than their being required to visit a bricks and mortar facility for treatment. But providers can only continue to offer this person-centered care if the reimbursement of all telehealth services including but not limited to audio-only services are reimbursed on par with face-to-face care. Operational costs associated with providing telehealth care are considerable and are not 'one-time' expenses. The expenses associated with providing care through a qualified practitioner do not change when the client is being seen outside of the clinic. For these reasons, we vigorously support this proposal that would ensure payment parity in the Medicaid Program and in the private health plan/commercial markets where rates of reimbursement paid to the behavioral health provider for services rendered to an individual with private insurance **are on average 50% less than the required government rate for the exact same service provided to a Medicaid client.** We urge the members of this Committee to support this proposal and in doing so, ensure that (finally) New Yorkers with serious mental health and/or substance use disorder challenges can access care on their own terms and without having to take time from work, travel long distances to receive services.

HMH, Article VII, Part C - Removes requirement for NP in primary care with over 3600 hours experience to maintain a collaborative relationship with physicians

The NYS Council supports this proposal to remove a barrier that currently prevents some Nurse Practitioners from practicing at the top of their scope without having to secure a formal collaborative agreement with a physician. Practitioners that possess this level of experience are needed now more than ever given current workforce shortages in all areas of healthcare. **Our concern is that this proposal only appears to create flexibility for NPs working in primary care settings.** Workforce shortages in behavioral health settings are severe. The limited availability of individuals who are permitted to prescribe certain lifesaving medications has reduced access to care at a moment in time when demand for medication and other services has never been higher. **As such, we strongly recommend this proposal be amended to include behavioral health as well as primary care settings, and that Psychiatric Nurse Practitioners be afforded the same flexibility as Nurse Practitioners discussed in this proposal.**

HMH, Article VII, Part U Improve access to children's mental & behavioral health services by aligning Child Health Plus benefits with other Medicaid benefits (HMH, Article VII, Part U)

The children's mental health system is under extreme pressure due to a lack of adequate access to care for children and youth in need of mental health and/or substance use services. Children and youth covered by Child Health Plus insurance should have the same opportunities to access the range of services that are currently available to those with Medicaid insurance. CFTSS and HCBS services that are not currently available to children with Child Health Plus insurance should be made available to them immediately to help address complex trauma, grief and loss issues associated with the COVID-19 pandemic. Aligning Child Plus benefits with other Medicaid benefits and bringing the reimbursement rates for CHP on par with Medicaid reimbursement will make it possible for providers to serve more children and youth and provide badly needed access to and continuity of care to New York's most vulnerable population.

HMH, Article VII, Part BB – Eliminates Prescriber Prevails option in Medicaid Managed Care and Medicaid FFS program

Once again, we find our ourselves having to oppose this proposal that we view as pennywise but pound foolish and completely antithetical to good practice. Individuals served in the mental health system who take psychotropic or other medications to remediate the symptoms of their mental health and often related physical conditions often spend years working with their physicians to identify the appropriate regimen of medications that allows the individual to be a productive member of his community and maintain long periods of community tenure. Removing the ability of a trusted physician (in collaboration with the patient) to make the final decision as to which medication/s will give the client the best opportunity to remain stable, extend his/her recovery and avoid hospitalizations and use of other acute care services will ultimately save New York State money. Medication management that is solely based on cost is dangerous and flies in the face of a person-centered approach to care. New York would be wise to accept the fact that when a client is taking a cocktail of medications and he/she has found the right combination of medications that results in long periods of time without need for more acute or emergency services, this is worth the cost associated with paying for a medication identified by a practitioner who understands how these medications work alone and in combination better than a finance person or a gatekeeper at an insurance company.

HMH, Article VII, Part EE - Expand Access to Naloxone and Buprenorphine in Pharmacies

Over 100,000 Americans have died as the result of an opioid overdose. Here in New York, this public health emergency must be met with the same level of resources and smart strategies as we would devote to any other public health crisis. This would include requiring pharmacies to carry a 30-day supply of two lifesaving overdose reversal medications and making both medications as easy for any New Yorker to acquire as possible. This proposal that would require pharmacies to keep these critical reversal medications on hand makes sense and will result likely result in countless overdose reversals that give the impacted individual an opportunity to address his/her addiction and recover. The disease of addiction is a chronic and relapsing condition. As such, we need to reduce the stigma associated with these medications and make them readily available to any New Yorker upon request.

HMH Article VII, Executive, Part D - Proposal to provide Healthcare Workforce bonuses to Health and Mental Hygiene employees

This proposal to provide healthcare workers, including those who work in mental health and substance use disorder/addiction programs and services, eligible for a one-time bonus of up to $3,000/employee based on hours worked and time on the job will assist the community-based organizations that are currently struggling to recruit and retain workers who have left our agencies for a variety of reasons, beginning with the disproportionately low wages they receive as compared to similar jobs in the state system as well as hospitals, and other institutional settings. The emotional toll associated with working with very challenging clients in combination with low salaries has left our workforce depleted. *This has a direct impact on access to care throughout the mental health and substance use disorder systems of care at precisely the moment when demand for care has never been higher.* The proposal to provide bonuses will certainly help our organizations retain current employees. However, it should be noted that this proposal does not in any way negate the need for the Human Services COLA (HMH, Article VII, Part DD) and other rate increases that are proposed as result of an influx of federal funds.

ATL OASAS SFY ***2022-2023 Executive Budget Bill – Appropriation of $1.5M from Behavioral Health Parity Compliance Enforcement Fund to OASAS***

This proposal would direct a portion of parity compliance enforcement funds to OASAS for purposes of expanding the Mental Health and Addiction Ombudsman Program (CHAMP). As a partner in the CHAMP Program, the NYS Council vigorously supports this proposal that would permit CHAMP to grow thereby

providing more in-person coverage in counties and regions across the state where community members can receive assistance with accessing their health insurance benefits, and to find treatment options to address their behavioral health needs.

Demand across New York for mental health and/or substance use disorder services has never been higher while the ability of most New Yorkers to understand the benefits that are included in their insurance plan remain deeply complicated. CHAMP provides a hotline New Yorkers can call to speak with an individual who is highly trained to assist the caller with understanding their benefits and then utilizing them to meet their healthcare needs. In addition, CHAMP helps New Yorkers with complex mental health / addiction issues as well as their families and loved ones who are trying desperately to identify services for their loved ones. There are currently waiting lists across the state for many mental health services and in many instances, it takes an expert to assist with the task of finding treatment for a loved one. Finally, CHAMP assists New Yorkers who want to file complaints or seek legal assistance to file a grievance or appeal against an insurer that has issued a determination that has the effect of denying care to an individual in need. CHAMP is incredibly successful in these matters with a very high rate of winning the appeals they help clients to file. This would not be the case unless the practices of certain insurers were less than honorable. For these reasons, we strongly support these funds to be appropriated to OASAS for purposes of expanding the CHAMP and making these consumer services more available in local communities across New York.

Suggestions for <u>additional criteria</u> (beyond that which is proposed in Part P) the state can use to evaluate Competitive Bids from MCOs interested in participating in the carve-In of Behavioral Health Services to Medicaid managed care (Part P proposal)

Provider Feedback:
Providers should be encouraged to submit, and the state should consider the content of Letters of Support submitted by providers that transact business with various MCOs seeking to participate in the carve in of behavioral health services.

Organization structure:
There needs to be much more emphasis on staffing levels, especially in provider network-related roles.

Operations:
Emphasis and testing of readiness to adjudicate and pay claims correctly all standard payment types for all provider types

Emphasis and testing of readiness to accept, adjudicate and pay correctly all standard electronic claim transactions, including secondary claims and zero-fill claims

Demonstrate sufficient and ongoing investment in systems, especially claims payment systems

Review standard claims processing metrics - % denied claims using standard denial codes, average days from claims receipt to payment, % throughout (processed through system without manual intervention), # of adjustments per month and as % of claims processed

Provider Call Center Standards:
90% of calls answered within 30 seconds
Hold time not to exceed 30 seconds
>3% dropped calls

All inquiries that require a call back must be returned within one business day
Minimum 70% of all calls resolved during 1st call

Network:
Plans should be able to demonstrate greater than 95% of all care provided by network providers (review percentage of care provided by OON providers – should not be concentrated in any specialty e.g.: mental health)

State should compare networks of all bidders to determine overlap – select plans with the least number of gaps (most plan networks in each region will be substantially similar)

State needs to set adequate targets for network adequacy for all provider types

Benefits to State of competitive procurement resulting in fewer plans:
Providers will have larger number of members concentrated in fewer plans allowing more opportunity for VBP arrangements

State is currently unable to do sufficient monitoring and surveillance over such many plans. Reducing overall number of plans across the state will enable State agencies to do more oversight